MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes ( ) No
Requestor's Name and Address Houston Premier DME 4141 North Freeway, Ste. 206 Houston, TX 77022	MDR Tracking No.: M4-04-1789-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 54 Texas Mutual Insurance Company	Date of Injury: Employer's Name: D Ambra Steel Service Inc. Insurance Carrier's No.: 99C / 324498

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/31/02	10/31/02	L0565	445.05	$100.05
Total Amount Due				$100.05

PART III: REQUESTOR'S POSITION SUMMARY

Among the sample EOBs from various carriers, there are some showing full payment made by this Respondent for the same type of DME.

PART IV: RESPONDENT'S POSITION SUMMARY

"F" – Fee dispute

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The original EOB denial reason of medical necessity was resolved upon reconsideration and partial payment issued by the Respondent. The reconsideration EOB indicates payment $49.95 was made in accordance wit the MFG MAR. However, according to the 1996 MFG, Medicine Ground Rule IX. Billing (C), fair and reasonable reimbursement is the same as the rates set for the "D" codes in the 1991 MFG.

The Requestor billed L0565, which is described as LSO anterior-osterior-lateral control, custom fitted brace. This item is the same as the D0522 Lumbo-sacral back brace w/steel straps (custom fitted). The purchase price for this item in the 1991 MFG is $150.00.

The Requestor is owed the difference between the $150.00 fair and reasonable rate and the amount previously paid by the Respondent or $100.05.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$100.05**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Patti Lanfranco	June 30, 2005
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
P. O. Box 17787
Austin, Texas, 78744
or faxed to (512) 804-4011

A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____